

Rosenthal Cosmetic Surgery & Skin Care Center
140 Sherman Street
Fairfield CT 06824

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

- *Obtain payment from third party payers.

- *Conduct normal healthcare operations such as quality assessments and physician Certifications

I have been given the opportunity to acquire a summary of your Notice of Privacy Practices and understand that I have access to the Notice containing a more complete description of the uses and disclosure of my health information. I understand that this office has the right to change its *Notice Of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name: _____

Relationship(if patient is a minor): _____

Permission to Speak with Family Members: Y ___ N ___ If yes, whom:

Date: _____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date: _____

Initials: _____